HEALTH

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MEDICARE PRESCRIPTION DRUGS

Background

The President's budget proposes a voluntary prescription drug benefit for all Medicare beneficiaries. The new Medicare Part D would pay half the cost of prescription drugs up to a limit, and would be financed by premium payments from enrollees and general Treasury revenues. The proposal would cost $28.8 billion over 5 years, according to the administration.

The Medicare program provides health insurance coverage for citizens over 65 and certain disabled persons. The program does not cover the cost of most prescription drugs. But roughly 65 percent of beneficiaries obtain some degree of prescription drug coverage through other plans or through Medicare+Choice health plans.

Under the President's proposal, the benefit would be structured as follows:

< No deductible – The benefit would begin with the first prescription, paying half the cost.

< Benefit limit – The Government subsidy would be up to half of the designated coverage limit for the year. The government would <u>not</u> cover costs above the limit. For calendar years 2002 and 2003, the coverage limit would be $2000 and would phase up to $5000 by 2009. Thus the government subsidy would be up to $1,000 in 2003, phasing up to $2,500 in 2009.

< The benefit would be available through Medicare fee-for-service, and all Medicare+Choice plans would be required to offer coverage.

< The proposal would require Medicaid to cover the cost of the program for low- income beneficiaries. It would cover all premium and co-payment costs for those with incomes below 135 percent of poverty, and on a sliding scale for those between 135 and 150 percent of poverty.

< The President would subsidize employers whose retiree prescription drug coverage would be at least as generous as the government plan. This is designed to prevent employers from dropping retiree coverage.

- Beneficiaries in Medicare fee-for-service would receive their prescription drugs through Private Benefit Managers [PBMs], retail drug chains, health plans, or insurers. Medicare would contract with private entities to administer the benefit. Periodically, PBMs would competitively bid for the exclusive contract for a geographic area.

- The President would establish a $35 billion reserve fund beginning in 2006 in the event that Congress and the President agree on policy to provide Medicare beneficiaries protections against catastrophic prescription drug costs.

In 1988, Congress passed and the President signed into law the Medicare Catastrophic Coverage Act. Among other benefits, the law established a limited prescription drug benefit for home intravenous drugs and immunosuppressive drugs once the beneficiary met a $550 deductible. The law added a surtax on the Part B premium to finance the program. In response to severe objections by Medicare beneficiaries, the law was repealed the next year.

The National Bipartisan Commission on the Future of Medicare examined the prescription drug issue. Because none of the President's appointed commissioners voted for any recommendations, the Commission proposal did not receive the required 11 of 17 voted super-majority. But 10 commissioners on a bipartisan basis voted in favor of adding a targeted prescription drug benefit in the context of fundamental Medicare reform. All Medicare beneficiaries at or below 135 percent of poverty would pay no premium for drug coverage, those between 135 and 150 percent would receive discounts that phase down as income rises.

Key Points

- Last year, the Congressional Budget Office projected the President's Medicare prescription drug benefit would cost $168 billion over 10 years.

- More than 65 percent of Medicare beneficiaries currently have prescription drug coverage through private retiree health benefits, Medicaid, supplemental medical benefits, or Medicare+Choice.

- According to an AARP study, Medicare beneficiaries spent an average $410 on prescription drugs in 1999.

- Most Medicare beneficiaries would be worse off in the President's prescription drug plan. The break-even point, counting required premiums and co-payments is $605 – higher than average prescription drug costs Medicare beneficiaries are now paying.

- CBO estimated that Medicare prescription drug spending would increase 25 percent as a result of this subsidy.

HEALTH INSURANCE
FOR THE UNINSURED/MEDICAID/SCHIP

Medicaid/SCHIP

The President's budget proposes to spend $94.2 billion more in mandatory spending over 10 years to try to further accelerate the already increasing enrollment in Medicaid and the State Children's Health Insurance Program [SCHIP]. It is part of a $110-billion plan to provide federally subsidized health insurance to the uninsured.

The proposals for children would cost $5.5 billion over 10 years to: accelerate enrollment of children eligible for Medicaid or SCHIP by allowing school lunch programs to share information with Medicaid; expand the sites (such as child care centers) authorized to immediately enroll children in SCHIP and Medicaid before their applications are even processed; and require States to simplify Medicaid enrollment documentation requirements to be as minimal as those for SCHIP.

The proposals for adults would cost $88.7 billion over 10 years, including: 1) $4.3 billion to permanently extend an expiring provision of current law which allows those leaving welfare to retain Medicaid coverage; 2) $76 billion to create a new Federal program called "FamilyCare" to provide for States to extend Medicaid or SCHIP to parents of children eligible for these programs, or to pool State and employer contributions for the purchase of private health insurance that meet Medicaid or SCHIP standards; 3) $1.9 billion to give States the option to enroll 18- and 19-year-olds in Medicaid or FamilyCare; and 4) $6.5 billion to give States the option to provide Medicaid coverage to certain legal immigrants who entered the United States after the enactment of welfare reform, and to require all States to provide Medicaid to certain disabled immigrants.

The Balanced Budget Act of 1997 [BBA] already allows a total of $40.3 billion over 10 years in Federal matching funds for SCHIP children's health program. The Nation's Governors have argued that proposed regulations for SCHIP restrict needed flexibility and limit the State's ability to enroll more of the Nation's five million uninsured children who are eligible for SCHIP.

Key Points

< Extending health insurance to poor, uninsured children is a worthy goal, with strong bipartisan support.

< The Department of Health and Human Services has just documented that the States have doubled enrollment of children in the SCHIP program over the past year, from 1 million to 2 million children. The National Governors Association said these most recent SCHIP enrollment numbers prove that "States are doing an exceptional job of finding, reaching out, and enrolling children in state-designed health insurance programs."

< But at the administration's original insistence, the BBA restricts program administration, direct care, and outreach to 10 percent of total SCHIP funds. Then, last year, the President suggested partially reversing that limitation by allowing States to use up to 3 percent of their SCHIP benefit spending for outreach activities and removing outreach from the 10-percent administrative/direct care/outreach cap.

The Nation's Governors have complained that they are unable to fund SCHIP outreach appropriately because outreach is restricted by the 10-percent cap. Simply allowing States to administer SCHIP without Federal restrictions on how much they can spend on outreach would best allow these States to enroll more of the Nation's uninsured children.

< Now the President has requested an additional $5.5 billion over 10 years. But, neither Medicaid nor SCHIP is actually short of funds.

- Like Medicare, Medicaid funding is mandatory, so spending is unlimited to meet the requirements and demands of the existing statutory program. SCHIP Federal matching funds are capped at $24 billion over 5 years and $40.3 billion over 10 years, but the States are spending at a much slower rate.

- This slow spending is mainly the result of the 10-percent cap, which hamstrings the States in their efforts to enroll eligible children, and the time required to get a government program up and running. In other words, new funding proposals are not needed; more flexibility is needed.

- Commenting on proposed Federal rules for SCHIP, on January 7, 2000, the National Governors' Association stated "SCHIP should be an oportunity for some state to demonstrate the potential effectiveness of managed care, employer-based , and family coverage models in a program built upon public-private partnerships. We are disappointed that the most prescriptive of these regulations will make it more difficult, if not impossible, for states to create new and innovative health care delivery systems for the 21st Century."

< The President is proposing to allow school lunch programs to share application information with Medicaid staff for outreach and enrollment, a practice already allowed for SCHIP. This proposal mirrors legislation (S.1570) offered by Senator Richard Lugar (R-IN). Federal law currently prevents school lunch programs from sharing enrollment information with Medicaid.

< Senate Finance Committee Chairman William Roth (R-DE) recently stated "There is more that must be done – every child in this country eligible either for Medicaid or for SCHIP ought to be enrolled and receiving the coverage they need to grow and thrive." But even more progress on children's health care rests on economic growth which can increase family incomes and employment in jobs offering private health insurance coverage.

< The President is also proposing to expand Medicaid and SCHIP to have States cover

children all the way through age 20 and parents of children eligible for Medicaid or SCHIP. A tax credit approach, which would greatly expand plan choices and health insurance options open to the uninsured, would be far preferable to expanding a rigid government program.

< A key policy goal of the 1996 welfare reform law was to discourage immigrants from coming to this country to get public assistance. The President's proposal to revise the non-citizens provisions of the 1996 welfare reform law would undermine this policy objective.

< Currently, immigrants must have a sponsor who will agree to provide for the immigrants needs. To this end, the income and resources of the immigrant's sponsor are attributed to the immigrant. The President's proposal to revise the non-citizens provisions of the 1996 welfare reform law and provide public assistance to immigrants would shift costs to the taxpayer which the sponsor has agreed to pay.

< Most noncitizens who entered the United States after enactment of welfare reform have legally enforceable sponsorship agreements signed by the legal residents. These sponsors have promised to provide for the immigrants if they are unable to support themselves. The President would weaken the welfare reform law's effort to hold immigrants or their sponsors accountable for the promises they have made to be self-sufficient.

Waste, Fraud, Abuse, and Mismanagement

Medicaid continues to be subject to waste, fraud, and abuse. Among recent examples are the following:

< **State Defrauded of an Estimated $1 Billion** – In November 1999, Federal investigators announced that losses to the California Medicaid program (called Medi-Cal) may surpass $1 billion, one of the largest frauds against a State in American history. A joint Federal and State task force investigated the program after the number of medical supply stores skyrocketed, and payments for supplies jumped almost 50 percent between 1996 and 1998, from $173.4 million to $258.4 million. Charges have been filed against 64 businesses and their owners, 35 of whom have pled guilty and have been fined or are serving sentences ranging from 10 months to 3 years. An additional 300 businesses are currently under investigation.

According to accounts, loose government regulations of the Medi-Cal program have made it relatively easy for fraud rings to operate. The scam operations obtain Medi-Cal provider numbers, then start billing electronically for nonexistent supplies and services. *The Los Angeles Times* said: "The deception was so easy. Rent some office space. Put in a few shelves with a smattering of goods . . . Meet State standards so lax that only primary suppliers were expected to maintain records. Start billing the State Medi-Cal system for all sorts of fake sales and business and then just sit back and watch the checks come in." (*The Los Angeles Times,* 29 November 1999 and 1 December 1999)

- **Overcharging for Home Health Services** – Between January 1994 and November 1997, a New York home health agency submitted tens of thousands of inflated bills to Medicaid for home health care services. Medicaid was charged as much as 25 percent above rates charged to privately insured patients, resulting in Medicaid overpayments of $600,000. In March 1999, the owner of the agency pleaded guilty to grand larceny. (National Association of Attorneys General, *Medicaid Fraud Report*, March 1999)

- **Charging for Medical Services Not Delivered** – Between February and August 1996, a Miami-based medical clinic defrauded Florida's Medicaid program of more than $1,000,000. The clinic submitted fraudulent medical claims for nerve conduction tests, allergy tests, and chemotherapy injections which were not provided. (National Association of Attorneys General, *Medicaid Fraud Report*, February 1999)

MEDICARE BUY-IN

Also, part of this $110 billion package of health insurance for the uninsured, the President has again proposed opening Medicare benefits to those that have never before been eligible, and includes tax credits for the purchase of Medicare benefits.

- Individuals age 62 to 64 would have the right to buy into Medicare through a full premium until they turn 65. Eligible individuals would include early retirees, the self employed, and those not provided employer sponsored health coverage.

- Workers age 55 and older who are laid off could buy into Medicare.

- Employers who drop previously promised retiree coverage would be required to offer COBRA continuation coverage until the retiree reaches Medicare eligibility. A tax credit costing $10.3 billion over 10 years would be offered on the COBRA premium.

- The President proposes offering those eligible for the buy-in a tax credit equal to 25 percent of the full cost Medicare premium. This would cost $1.6 billion over 10 years.

Key Points

- Last year, CBO estimated the buy-in cost at 35.8 billion over 10 years, and revenues through premiums of $30.8 billion, for a net cost of $5.0 billion.

- CBO estimated an extremely low rate of participation in the program because of the stringent eligibility requirements.

- Those aged 55 to 64 are no more likely than the rest of the population to be uninsured, while young adults are more likely to be uninsured.

- The proposal gives a strong incentive for the 55 to 64 year old to leave the workforce and

receive government subsidized health insurance, eliminating essential revenues to the Medicare Trust Fund and adding costs.

Waste, Fraud, Abuse, and Mismanagement

The General Accounting Office [GAO] has retained Medicare on its list of "high-risk" programs, meaning it is exceptionally vulnerable to fraud and abuse. Some key problems:

< **Improper Payments** – Medicare's fee-for-service program made $12.6 billion in improper payments in fiscal year 1998, the most recent year analyzed. Although this appeared to be better than the previous year, the improvement was mainly the result of better paperwork, rather than changes in actual billing practices.

< **Fraud** – The improper payments quantified cannot account for any fraud the program suffers. Indeed, recent accounts show that Medicare has attracted its own class of organized criminals – persons who specialize in defrauding health care and health insurance systems.

< **Mismanagement** – Program administrators have failed to provide sufficient safeguards and oversight to assure Medicare funds are properly spent.

< **Flawed Payment Mechanisms** – Medicare grossly overpays for some services because of the nature of its own payment mechanisms – but the total amount of these excessive payments has not been quantified.

LONG-TERM CARE INITIATIVE

Background

The President proposed a long-term health care initiative costing $28 billion over 10 years. The plan would offer a $3,000 tax credit for people who are significantly impaired and need help caring for themselves. (The President proposed a $1,000 credit last year.) The patient could take the credit himself or designate a care giver as the beneficiary. To qualify, a person would need help with at least three of the five basic activities of daily living – bathing, dressing, using the toilet, getting in and out of bed or a chair, and eating – or having a disabling mental impairment such as Alzheimer's.

The proposed credit would be phased in, beginning with $1,000 in 2001and rising by annual increments of $500, so eligible people could receive up to $3,000 a year by 2005. The credit would cost an estimated $8.8 billion over 5 years and $26.6 billion over 10 years. Other long-term care initiatives, including Federal discretionary spending for State and local programs that support long-term care givers, expanded use of home and community-based services under Medicaid, partnerships between Medicaid and low-income housing for the elderly, and incentives to Federal

employees to purchase private long-term care insurance would bring the total to $10 billion over 5 years and $28 billion over 10 years.

About 1.6 million people receive long-term care in nursing homes, at an average of more than $50,000 a year. To qualify for Medicaid nursing home coverage, a person must become impoverished by "spending down" assets. In fiscal year 2000, Federal Medicaid long-term care costs will total $38 billion, or 33 percent of total Medicaid spending.

Key Points

< The President's $3,000 tax credit proposal does not address the need to move more of the Medicaid long-term care budget burden onto private long-term care insurance.

< A $500 tax credit for long-term care was a part of the Contract with America, but the Contract also allowed tax-free withdrawals from IRAs and other pension plans to buy long-term care insurance, and provided a tax deduction to offset the cost of purchasing long-term care insurance.

< Making long-term care premiums tax deductible would stimulate the purchase of private long-term care insurance and thereby relieve the budgetary pressure on Medicaid outlays for long-term care as the baby-boom generation begins to age and needs long-term care.

< In contrast with Clinton's proposal for a $3,000 long-term care tax credit (costing $8.8 billion over five years), for much less, all private long-term care premiums could be made tax deductible.

< Another approach to simulate the purchase of private long-term care insurance would be to remove Federal restrictions on State-sanctioned, long-term care policies that are coordinated with the Medicaid program, called Partnership policies.

- Provisions of the Omnibus Budget Reconciliation Act of 1993 [OBRA] placed Federal barriers to adoption by 46 States of innovative approaches to strengthen the incentives for purchase of private long-term care insurance.

- Prior to the OBRA 1993 restrictions, four States (California, Connecticut, Indiana, and New York) had enacted a Medicaid public-private partnership program that protects consumers from depletion of their assets in the financing of long-term care.

Waste, Fraud, Abuse, and Mismanagement

< The President's proposed $3,000 tax credit could attract fraud. How, for example, will

family members document that they actually have taken care of their ill relative?

< Will doctors have to sign the 1040 form stating that the relative was ill and how much time the family member took care of the person?

VETERANS HEALTH CARE

Background

The President's fiscal year 2001 budget includes a $1.5 billion increase in discretionary spending for veterans' programs, including $1.4 billion more for veterans medical care. In total, Department of Veterans Affairs [VA] spending would be $47.9 billion in budget authority, including $20.9 billion in discretionary spending for medical care. Veterans total outlays would decline from $46.7 billion in fiscal year 2000 to $46.5 billion in fiscal year 2001 because of a $1.1 billion reestimate of the veterans housing benefit program account. The President's budget also contains a legislative proposal to shift the payment of $1.8 billion in veterans compensation from Monday, October 2, 2000 (fiscal year 2001) to Friday, September 29, 2000 (fiscal year 2000).

Key Points

< Support for the Nation's veterans has long been a top Republican policy priority.

< In fiscal year 2000, the Congress added $1.7 billion for veterans medical care over and above the President's request. This was the largest increase in the history of the program.

< While President Clinton implemented a statutory governmentwide discretionary spending cut that protected his highest priority areas of government, he did not protect the discretionary spending for veterans medical care. An $80-million cut in VA medical care was included among his lower priority areas targeted for cuts.

< Total VA spending (in budget authority) has risen from $38.2 billion in fiscal year 1995 (the last Democrat Congress budget) to $47.4 billion in fiscal year 2000 (a 24.2-percent increase).

< While VA spending has been increasing, the number of veterans in the Nation has been declining from 26.1 million in 1995 to 24.3 million in 2000 (a 7-percent decrease). A further decrease to 22.2 million is expected by 2005.

< Taken together, the real spending increases provided the past 5 years, combined with the slimming veteran community, has provided more than a 25-percent increase in the actual level of commitment to each former member of the American Armed Forces.

Waste, Fraud, Abuse, and Mismanagement

Veterans spending continues to be subject to waste, fraud, and abuse. Among recent examples are the following:

- **Sleeping on the Job** – A VA registered nurse routinely slept during her shifts. For the majority of the nights she worked, she was the only registered nurse assigned to her unit and the only staff member allowed to dispense medications to patients. (Department of Veterans Affairs IG, *Semiannual Report to the Congress*, March 1999)

- **Murdering Patients** – A VA nurse in a critical care unit was indicted on 11 counts, including the murder of three patients, the attempted murder of two other patients, an assault, and obstruction of justice. The indictment charges that the nurse used a heart stimulant to murder or assault the patient in her care. (Department of Veterans Affairs IG, *Semiannual Report to the Congress*, March 1999)

- **A Fence for the Pet** – A VA senior official at the Alvin C. York VA Medical Center improperly requested and approved construction of a $5,000 fence at the government quarters he occupied, in part to accommodate his pet. (Department of Veterans Affairs IG, *Semiannual Report to the Congress*, March 1999)

- **Gambling** – A VA supervisor at the VA Medical Center Biloxi, MS, granted administrative leave to her subordinates – so they could attend monthly social activities at a gambling casino. (Department of Veterans Affairs IG, *Semiannual Report to the Congress*, March 1999)

NATIONAL INSTITUTES OF HEALTH

Background

The President has proposed $18.8 billion in discretionary spending for the National Institutes of Health [NIH] in fiscal year 2001, an increase of $1 billion. NIH funding for fiscal year 2000 is $17.8 billion.

In addition, the President has proposed releasing the $810 million of NIH funding that was supposed to be held until fiscal year 2001 (delayed appropriation).

As shown in the table below, NIH appropriations have increased rapidly, rising from $11.3 billion at the end of the Democrat-controlled Congress to the almost $18 billion today.

NIH Appropriation Level and Annual Percentage Change
(budget authority, in billions of dollars)

Fiscal Year	1995	1996	1997	1998	1999	2000
Appropriated	11.284	11.928	12.741	13.648	15.652	17.833
% Change	3.3	5.6	6.8	7.1	14.7	13.9

Key Points

< As is clearly demonstrated from the chart above, NIH has long been a Republican spending priority. Basic research to produce needed medical data and information in support of finding cures for disease is both a fundamental public good and a smart strategy to help control health care costs, including those borne by the taxpayers through government programs.

< The Republican Congress has already increased NIH by 58 percent since becoming the party in control in 1995. The Republican-controlled Congress has led the effort for more NIH funding.

- In his fiscal year 1998 budget, the President only proposed a 2-percent increase in NIH funding. The Congress provided a 7.1-percent increase instead.

- In fiscal year 1999, the President then proposed an 8.4-percent increase, but only through money from the unrealized national tobacco settlement. The Congress rejected this phony funding scheme and provided a straight 14.7-percent increase.

- Finally, in fiscal year 2000, the President proposed a 2.4-percent increase; the Congress provided another 14.7-percent increase.

< When Congress and the President agreed to a 0.38-percent across-the-board spending

reduction for fiscal year 2000, the administration insisted on flexibility in distributing the cuts. Now, while sparing certain programs, the administration cut $100 million from NIH – nearly twice the 0.38-percent amount. This reduced the fiscal year 2000 growth rate to 13.7 percent and reduced Congress's appropriated increase in funding by more than 5 percent.

< Just 2 years earlier, in his 1998 State of the Union message, President Clinton had called for increasing NIH funding by 50 percent over 5 years and a doubling over the next 10.

< In light of this massive infusion of grant spending – $6.5 billion of increased resources being spent by NIH annually – an evaluation and reassessment of the agencies programmatic success and priorities may be timely.

Waste, Fraud, Abuse, and Mismanagement

< The General Accounting Office [GAO] is expected to issue a report within the next few weeks that will assess the NIH's use of increased funds over the past few years. This should be closely studied before decisions are made with regard to fiscal year 2001.